For Office Use Only	
Date of Acceptance	Date of Discharge

KIDS PLACE AFTER SCHOOL PROGRAM
CHILD ENROLLMENT FORM
2021-2022

Jewish Community Center of Greater Buffalo
2640 N. Forest Road, Suite 100, Getzville, NY 14068, 716-688-4114 ext. 303
787 Delaware Avenue, Buffalo, NY 14209, 716-716-886-3172 ext. 420

CHILD INFORMATION

Child's Name		Grade as of Sept. 2021		D.O.B	
Child's Home Address					
Home Phone #		School		Religion	
Parent/Guardian #1 (person enrolling child)		E-mail Address			
Phone (C)	☐ Ok to Text	Phone (W)			
Parent/Guardian #2		E-mail Address			
Phone (C)	☐ Ok to Text	Phone (W)			

Parents Marital Status	☐ Married	☐ Single	☐ Divorced	☐ Separated	☐ Widowed	☐ Other:
Child Primarily Lives With	☐ Both	☐ Parent #1	☐ Parent #2	☐ Parent 1 & 2, Equal Custody		☐ Other:
How did you hear about us:	☐ JCC Early Childhood	☐ Sign	☐ Friend/ Family	☐ Online search	☐ Newspaper/ Magazine Ad	☐ Other:

TRANSPORTATION

☐ I have arranged transportation with my child's school Bus Number: _____ Arrival Time:_____	☐ I will provide transportation for my child

EMERGENCY CONTACT & RELEASE INFORMATION

I give permission for the Kids Place staff to release my child ONLY to the following individuals. I understand that if my child is not picked up by 6:00 p.m., I will incur a late fee charged to my account. **Photo ID is REQUIRED before the child will be released.**

	Contact Name	Authorize to Pick Up	Relationship	Telephone During Childcare	Other Telephone Number
Emergency Contacts		☐ Yes ☐ No	**Primary Caregiver**	☐ Ok to Text	☐ Ok to Text
		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text
		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text
		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text
My Child May Also Be Released To		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text
		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text
		☐ Yes ☐ No		☐ Ok to Text	☐ Ok to Text

•OVER•

CHILD INFORMATION CONTINUED			
Child's Name		D.O.B.:	

MEDICAL INFORMATION	
Does your child have any allergies, intolerance or dietary restrictions? Please be as specific as possible.	☐ Yes ☐ No
If yes, please explain reaction:	
Does your child require emergency medication? (Epi Pens, Asthma Inhaler, etc.)	☐ Yes ☐ No
If yes, please explain: **(Medication Administration Consent form and Individual Health Care Plan form MUST be on file for emergency medications.)**	
Does your child take any other medication during the day? We will use this information for emergency purposes only.	☐ Yes ☐ No
If yes, please explain:	
Does your child receive special education services, therapies, or other support services?	☐ Yes ☐ No
If yes, please check & explain below: ☐ Special Education ☐ Occupation Therapy ☐ Speech/Language ☐ Physical Therapy ☐ Other:	

PHYSICIAN INFORMATION			
Child's Source of Medical Care/Primary Care Physician:		Phone:	
Child's Source of Dental Care/Dentist:		Phone:	
Preferred Emergency Medical Care Facility/Hospital:		Phone:	

Child health insurance information is available by calling 1-800-698-4543 or online https://nystateofhealth.ny.gov

AGREEMENT		
I consent to the enrollment of the child listed above in this facility and I understand the program must provide a written policy statement at the time of enrollment as required by regulation.	☐ Yes ☐ No	Initial:
I grant permission for the Kids Place staff to drop off my child at the Jewish Community Center Aquatics and Recreation facilities so he/she will be able to participate in swim lessons and aquatics programs as well as fitness games and activities, etc. Furthermore, I grant permission for Kids Place staff to escort my child to other enrichment activities that he/she is enrolled in during the program.	☐ Yes ☐ No	Initial:
I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.	☐ Yes ☐ No	Initial:
I give consent for my child to take part in neighborhood trips under proper supervision.	☐ Yes ☐ No	Initial:
I consent to emergency medical treatment for my child	☐ Yes ☐ No	Initial:
I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child.	☐ Yes ☐ No	Initial:
I agree to review and update this information whenever a change occurs and at least once every year.	☐ Yes ☐ No	Initial:

X_____ _____
Signature of Parent or Person Legally Responsible Date